

Health Disparity Collaboratives Support Better Patient Care

An innovative national effort to improve chronic illness care for underserved groups is yielding impressive results. The Bureau of Primary Health Care's Health Status and Performance Improvement Collaborative—known informally as the Health Disparity Collaboratives—brings together health center staff, clinical experts, and experts in systems change and chronic illness care.

Together, these groups study and test ways to close the gap between what is known to be effective for the care of people with chronic conditions and what is applied in clinical or public health practice. "This is a very powerful and exciting program, and it works," says Tricia L. Trinité, NP, director of Health Disparity Collaboratives.

Eliminating Health Disparities

Part of the Health Resources and Services Administration's effort to eliminate health disparities in six key areas—infant mortality, immunizations, diabetes, cardiovascular health, cancer, and HIV—the Health Disparity Collaboratives will begin their third cycle of programs this fall. Teams of clinicians and administrators from 88 health center programs—

including Community and Migrant Health centers, Health Care for the Homeless programs, and Public Housing grantees—completed a Diabetes Collaborative in 1999, and another 120 health centers are participating in a similar program this year. Collaboratives planned for 2001 include Diabetes III, Cardiovascular I, Prevention I, and Cancer I.

In addition, the Bureau is supporting attendance by 40 health centers at a Collaborative on asthma/depression sponsored by the Boston-based Institute for Health-

care Improvement (IHI). The IHI Breakthrough Series, which features shared learning and rapid system change, is the basis for the Bureau's Health Disparity Collaboratives. IHI's rapid cycle improvement method, called a PDSA (plan, do, study, act) cycle, emphasizes making a systems change quickly but on a small scale, so it can be tested before spreading it to the rest of the organization.

The Chronic Illness Model

Health center teams that participate in a Bureau Collaborative attend three, intensive, two-day learning sessions where they are taught to use rapid cycle methodology to implement a model for chronic illness care developed by the W.A. (Sandy) MacColl Institute for Healthcare Innovation at the Group Health Cooperative of Puget Sound, Seattle, WA. The model has been adapted by the Robert Wood Johnson Foundation for its National Program for Improving Chronic Illness Care.

Specifically, the model points to needed changes that will move a health care system from one of acute care to one in which proactive practice teams interact with activated and informed patients. The end result, Trinité says, is increased functional and clinical outcomes for patients.

The model's six essential elements are as follows:

- **Community Resources and Policies.** Chronic illness care can be improved if links are made to appropriate community resources that support patients, such as peer support and long-term care.
- **Health System Organization.** Health system change needs to be accompanied by a larger vision and visibly supported by senior leaders, Trinité says.
- **Self-Management Support.** The use of self-management goal sheets to

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In This Issue

The theme of this issue—"Tools for Change: Collaboration and Advocacy"—is reflected throughout. Working together on behalf of homeless people is key to the success of programs as diverse as Philadelphia's street ordinance Task Force and HCH racetrack programs.

We'd like to know about other successful collaborations. Contact the HCH Information Resource Center at (888) 439-3300, ext. 247.

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HCH Cares for the “Underbelly of Life” at Racetracks

The world of thoroughbred racing is filled with pomp and circumstance. Well-heeled owners race million-dollar horses for thousands of dollars in prize money.

Not far from the glamour, however, is a different world, one that Jim O’Connell, MD, president of the Boston Health Care for the Homeless Program, calls “the underbelly of life.” On the backstretch, thousands of migrant workers serving as grooms, stablehands, and hotwalkers (those who walk the horses to cool them down after a race) live and work in relative anonymity amid deplorable conditions.

The backstretch workers make less than minimum wage, have no health insurance, and no vacation or sick days. Many are illegal immigrants, grateful to have the work. Some of them live in tack rooms—concrete enclosures with no running water designed to hold racing equipment. Addiction to alcohol, drugs, and gambling is common. Most are men and many are young, but some families and elderly people are part of the workforce, as well.

“I really had my eyes opened,” says Jim Greene of Methuen, MA, who founded the Eighth Pole, Inc., a substance abuse recovery program that opened in 1989 at Suffolk Downs in Boston and at nearby Rockingham Park in Salem, NH. “I didn’t understand the depth of the poverty and deprivation or the breadth of the substance abuse problem,” says Greene, a horse owner, former trainer, and recovering alcoholic.

As a horseman himself, Greene is not proud of the situation. But neither is he overly critical of horse owners and the trainers who employ the backstretch workers. The horse racing industry, Greene says, is grossly underfinanced, with horse owners spending millions of dollars to chase dwindling prize

money. “There’s barely enough money to survive in this business, much less to care for others,” he says.

Collaboration with HCH

Greene has learned well the importance of collaboration when money is tight. In 1992, he approached Dr. O’Connell about providing some basic health care to the backstretch workers. Disturbed by their living conditions, Dr. O’Connell was nonetheless fascinated by the people he met.

“They work 60 to 100 hours a week for slave wages, yet they are fiercely proud,” he says.

Since that first meeting, HCH physicians volunteered at the track. This year, thanks to funding from the Bureau of Primary Health Care, Boston HCH now sends physician Claire Carlo, MD, and nurse Trish MacWilliams, RN, to both tracks (Suffolk Downs operates from September to June, and Rockingham Park in the summer months) one full day a week. MacWilliams returns for an additional half a day to do follow-up.

Dr. Carlo treats a host of chronic health problems such as diabetes, high blood pressure, and heart disease, but she also sees a high percentage of job-related injuries, including kicks, bites, and fractures. Fluent in Spanish, she has developed a good working relationship with her patients. “I think they’re grateful to have us here,” she says. Greene and his partner, trainer Shirley Edwards, transport patients to Boston Medical Center for follow-up and specialty care.

“I’ll See the Vet”

A similar program operates at Florida’s Gulfstream Racetrack and Calder Raceway. At Gulfstream Racetrack, the program is a collaboration between His Place Ministries and the North Broward County Hospital District’s Health Care for the Homeless program in Ft. Lauderdale, which received new access points funding from the Bureau to serve the backstretch workers.

HCH staff offer a full range of medical services, and His Place Ministries provides food, clothing, transportation, recreation, and translation services. At Calder, HCH staff from Broward County work with residents from a nearby medical school. Specialty care is available at Broward General Hospital.

The HCH team is at Gulfstream two days a week during the 13-week racing season and at Calder, which boards horses, one day a week year round. But a veterinarian is available to treat the horses everyday, notes Bernard (Bernie) Alicki, manager of the HCH program. “Often when a backstretch worker get sick, he says, ‘I’ll go see the vet,’” Alicki says. “That blew me away.”

Part of the Community

Greene knows that poverty, lack of access to medical care, and addiction are not unique to backstretch workers. A big part of the solution, he believes, is for communities to embrace their local racetracks and consider its migrant work force as part of the community itself. “Our problems are society’s problems,” he says. For more information, contact Dr. Jim O’Connell at (617) 414-7763 or jimoconnell.bhchp@juno.com or Bernie Alicki at (954) 355-4938 or balicki@nbhd.org. ▲

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Diagnosis & Treatment of System Failures: A Call for Clinician Advocates

By Pat Post, Communications Manager
National Health Care for the Homeless Council

Clinicians are trained to think diagnostically about individual patients' problems. They should apply these same analytic skills to identifying and reforming flawed policies and systems that cause or prolong homelessness and its associated morbidities, observes Nate Nickerson, MSN, ANP, director of the Portland Public Health HCH program in Portland, Maine. Clinicians serving homeless people have "unique and compelling perspectives on the problems these patients face, and special spheres of influence that increase their effectiveness as advocates," Nickerson says.

In fact, not only do clinicians have both the insight and the opportunity to effect system and policy changes, they also have a professional obligation to do so, according to Tony Halton, MSW, who coordinates health care entitlement outreach to homeless children residing in Tennessee emergency shelters. "Direct service providers must help policymakers understand what is clinically and practically feasible for persons experiencing homelessness," Halton says.

Matias Vega, MD, medical director of the Albuquerque HCH in New Mexico, thinks advocacy should be written into the job descriptions of HCH clinicians, and that project administrators should give them time and recognition to advocate as an integral part of their work. "We must improve service systems and address the root causes of homelessness to make a long-term impact on the problems we see in our practices," Dr. Vega says.

Impressive Results

Dramatic changes have resulted from the involvement of HCH clinicians in policy advocacy:

- A mental health collaborative in Portland, Maine, convened by Nick-

erson, developed a community plan to improve services for mentally ill homeless persons. Outreach to shelters, housing for persons with long-term mental illness, better hospital discharge planning, and ongoing monitoring of service adequacy are among the concrete results of their collective advocacy.

- Homeless advocates in Indianapolis, Indiana, developed a continuum-of-care plan that significantly increased federal funding for homeless services and inspired local funders to support the development of a homelessness prevention plan. Dr. Vega was instrumental in achieving these results, and is spearheading efforts to replicate them in Albuquerque.
- A city-county task force on homelessness in Minneapolis/Hennepin County, Minnesota, recommended increased funding for homeless services and more low-cost housing. HCH project administrator, Chris Reller, MSN, Hennepin County

TIPS FOR CLINICIAN ADVOCATES

To encourage homeless service providers to shift their focus from crisis management to prevention, and from advocacy for individual clients to advocacy for larger populations, HCH clinicians offer the following tips:

- **ACT LOCALLY.** The bottom line is what's happening in your own community, where you have the most influence and access to policymakers.
- **THINK HOLISTICALLY.** Address all needs of the homeless community: housing, transportation, childcare, job and life skills training, as well as legal, mental health, and substance abuse services. Learn outside your discipline and advocate beyond your vested interests for maximum impact.
- **BUILD RELATIONSHIPS.** Educate other service providers and policymakers to help homeless clients navigate mainstream health systems and obtain access to low-cost housing.
- **WORK THROUGH COALITIONS.** Participate in broader policy advocacy through local coalitions, task forces, and state Primary Care Associations.
- **INVOLVE ALL STAKEHOLDERS.** Collaborate with representatives of all groups that have a direct or indirect interest in stemming homelessness. Finding common ground with potential adversaries will increase your credibility with policymakers.
- **EMPOWER CLIENTS.** Advocacy is about adding essential voices to public discourse. Ensure that homeless persons' voices are heard; tell their stories when they are unable to speak for themselves.

Health Department, serves on this task force, in which government officials, HCH clinicians, clients, and other advocates participate.

- A stakeholder group including managed care organizations persuaded local health departments in Tennessee to facilitate same-day enrollment of homeless children in Medicaid managed care. Halton, the catalyst for this initiative, coordinates a three-year outreach effort to emergency shelters spearheaded by the National Health Care for the Homeless Council in partnership with the TennCare Bureau, the Tennessee Department of Human Services, and the U.S. Department of Housing and Urban Development.

Read more about "Clinicians as Advocates" in the April 2000 issue of *Healing Hands*, the newsletter of the HCH Clinicians' Network, at www.nhchc.org/hands.html. See also Advocacy Tips for HCH Projects at www.nhchc.org/advocacy.html. ▲

Consensus Decision-Making: A Tool for Collaboration

To Ken Kraybill, MSW, “consensus” is more than a fancy buzzword for group decision-making. “Consensus undergirds every aspect of how I work,” says Kraybill, supervisor of the downtown mental health team at the Seattle/King County Health Care for the Homeless Network in Seattle, WA. Kraybill uses consensus decision-making in his work with staff and clients, and he has helped train members of the National Health Care for the Homeless Council and the HCH Clinicians’ Network in its use. Still, he acknowledges that using this tool to make decisions represents a new way of thinking.

What is Consensus?

Consensus is both an outcome and a process, according to Sandor P. Schuman, president of Executive Decision Services of Albany, NY. As an outcome, consensus can be defined in many ways. In fact, Schuman suggests that it’s helpful for a group to “reach consensus on consensus.”

For example, group members may decide consensus means that each of them has had a chance to be heard, that the decision is one everyone can live with, or that the decision represents a specified level of agreement. Consensus is not a majority vote, it may not represent everyone’s first priorities, and it may not leave everyone equally satisfied. Further, consensus is not necessarily a unanimous decision, though some groups do reach consensus unanimously, Kraybill points out.

As a process, Schuman notes, consensus makes clear what behaviors are expected of group members. They have to listen carefully, speak clearly and thoughtfully, and respect one another’s points of view. Consensus decision-making, Kraybill says, “requires people to think about what’s in the best interest of the group as a whole rather than what’s in their own best interest.”

What Are the Advantages?

“The democratic virtue of consensus is appealing, if not compelling,” Schuman says. Indeed, consensus decision-making is an inclusive process. But, ultimately, he contends, consensus decision-making represents “brute pragmatism. It’s simply the fastest way to get things done.”

Many an organization has learned by experience that without the necessary “buy in” from group participants, implementation can be delayed or even derailed, Schuman notes. Though reaching decisions by consensus may feel like a lengthy process, it ultimately saves time by eliminating obstacles to implementation.

Reaching decisions by consensus is especially appropriate for the HCH setting, where diverse organizations and individuals have a stake in the outcome, notes Marsha McMurray-Avila, program coordinator with the National HCH Council. Consensus decision-making encourages

wider participation in the process and generates more potential solutions. However, it may not be appropriate for every situation.

“There are some decisions that are better made by whomever is accountable for the consequences of the decision, with relevant input from the affected parties,” McMurray-Avila says. These can range from clinical decisions, such as a provider’s diagnosis, to management decisions that have limited impact on the clinical team.

How is Consensus Accomplished?

There is no one rule book for consensus decision-making. However, certain principles are important, and there are a number of suggested ways to run a successful consensus decision-making process (see, for example, *On Conflict and Consensus*, in “Consensus Resources”). Key principles include the following:

- *Be certain the important players are in the room.* Ideally, key stakeholders should define the problem and set the agenda by consensus, Schuman notes.
- *Make sure the bulk of the work is done at the front end.* If consensus decision-making begins “the moment an idea is born,” Kraybill says, reaching consensus on a final decision is almost a formality.
- *Use collaborative problem-solving.* Collaborative problem-solving involves exploring a problem and identifying and resolving concerns.
- *Choose a facilitator carefully.* The facilitator’s job is critical in making sure that everyone has a chance to be heard and that agreed-upon time limits are kept. If the problem is especially contentious or poorly defined, it might be helpful to hire an independent facilitator, Schuman says. ▲

Consensus Resources

The following resources offer more information about consensus decision-making and group facilitation.

- Bens, I. *Facilitating with Ease! A Step-By-Step Guidebook with Customizable Worksheets* on CD-ROM. San Francisco, CA: Jossey-Bass, 2000. (800-956-7739; www.josseybass.com)
- Butler, C.T., and Rothstein, A. *On Conflict and Consensus*. Portland, ME: Food Not Bombs Publishing. (800-569-4054)
- Doyle, M., and Straus, D. *How to Make Meetings Work*. New York: Berkley Publishing Group, 1976 (reprint 1993).
- Schwarz, R. *The Skilled Facilitator*. Practical Wisdom for Developing Effective Groups. San Francisco, CA: Jossey-Bass, 1994. (800-956-7739; www.josseybass.com)

To find a professional facilitator, contact:

The International Association of Facilitators, 7630 West 145th Street, Suite 202, St. Paul, MN 55124, (612-891-3541; www.iaf-world.org).

People Like Me Campaign

Fifty thousand postcards bearing images created by homeless people with a message about universal health care are being distributed nationwide, to be signed by people without homes and sent to candidates for public office in the year 2000. Images selected to appear on the postcards were the winning submissions in an art contest arranged by the National Health Care for the Homeless Council. The National Council has launched the People Like Me Campaign to involve people experiencing homelessness in the political discussion of health care.

"This advocacy project offers a practical way of giving political voice to people in great need who are often disengaged from the political process," explains National Council Executive Director John Lozier. "It employs the creative strength of homeless people, and it recognizes the common needs of all people."

To see the winning art work and learn how you can participate in this exciting project, visit www.nhchc.org/peoplelikeme2.html. To order postcards for colleagues

and homeless clients, contact Beth Sharber at bsharber@nhchc.org or (615) 226-2292.

Network Member Profiles on the Web

The HCH Clinicians' Network is now posting monthly profiles of current members on the National Council Web site at www.nhchc.org/memberprofiles.html. Individuals profiled are selected from diverse clinical disciplines and geographical areas represented among the Network's membership. David Buck, MD, MPH, medical director of Health Care for the Homeless in Houston, Texas, and Betty Schultz, CPNP, RN, pediatric nurse practitioner at Mercy Children's Health Outreach Project, Baltimore, Maryland, are currently featured.

To learn more about the HCH Clinicians' Network, see www.nhchc.org/network.html. To become a member, fill out the form found at www.nhchc.org/networkform.html and mail it with the \$25 membership fee to HCH Clinicians' Network, P.O. Box 60427, Nashville, TN 27306-0427, or contact Pat Petty at (615) 226-2292.

Health Disparity Collaboratives (continued from page 1)

empower homeless patients to take responsibility for their care is an outgrowth of the first-year Diabetes Collaborative at HCH in Davenport, IA. "In the past we set our patients up for failure, by telling them what they had to do" says Mary Jo Bloominger, PA. "Now we support them to be successful by finding out what they can do for themselves."

- **Decision Support.** Providers need to be equally empowered and supported to use best-practice, evidence-based models of care for their patients with chronic disease.
- **Delivery System Design.** Changing a system that focuses on acute care might entail some creative scheduling, such as holding group clinics for diabetes patients, Bloominger notes.

- **Clinical Information Systems.** Creating registries with information about individual patients and patient populations allows a health care organization to track patients' care and to monitor provider and clinic performance on selected measures.

Improved Patient Care

The first-year Diabetes Collaborative used as its common outcome measure having 90% of diabetes patients receive at least two hemoglobin (Hb) A1c tests (which measure blood sugar control over the past three months), at least three months apart. All health centers met this goal, Trinité reports.

Bloominger notes that patients' actual HbA1c levels declined from 9.9 to 9.1 in one-three month period.

A HbA1c of greater than 10 puts an individual at risk for serious, long-term complications of diabetes, including eye, kidney, and nerve damage. Aside from the numbers, however, Bloominger recommends participation in a Collaborative because, she says, "The bottom line is we're seeing improved patient care."

For More Information

Applications for the 2001 Collaboratives will be available later this summer from the Bureau's cluster coordinators (<http://www.cnf.org/diabetes/cluster-coords.htm>). Collaborative teams must have the support of the program's senior leadership. For more information, contact Amy Taylor, MD, in the Bureau's Health Care for the Homeless Branch, at (301) 594-4455. ▲

Even in “Defeat,” Advocates Help Philadelphia’s Homeless

The homeless advocacy community in Philadelphia is nothing if not persistent, and that persistence has paid off handsily. Although a sidewalk behavior ordinance they opposed was eventually passed, they walked away with nearly \$6 million in new services for homeless people.

A Vigorous Opposition Campaign

In December 1997, when then City Council President John Street introduced a sidewalk behavior bill that called for criminal penalties for sitting, lying, and “aggressive panhandling” on city sidewalks, homeless advocates mounted a vigorous opposition campaign. They held public rallies and protests, attended City Council meetings, and met one-on-one with City Council leaders to propose alternative plans.

Their fear, notes Elaine Fox, director of the Philadelphia Health Management Corporation’s Health Care for the Homeless program, is that the sidewalk ordinance represented “the first step on a slippery slope” toward criminalizing homelessness. Working together, advocates succeeded in convincing Council leaders that, in Fox’s words, “the problem of homelessness is solvable, but not through punitive measures.”

After vigorous debate, the ordinance passed in June 1998, but the penalties had been reduced from criminal to civil. Further, the city pledged \$5.6 million for expanded outreach, treatment, and residential services and called for special training for police officers.

Before issuing a citation, police officers are required to contact outreach workers. They are only to issue a citation if the person refuses to move or to accept help. Thus far, there have been no citations under the ordinance, which went into effect in January 1999, and more than half of people approached have accepted help. “The situation is not perfect, but it’s a lot better than it could have been,” Fox says.

Remaining Vigilant

But Philadelphia’s advocacy community was not about to rest on its laurels. “We said we would be vigilant about how the provisions of the ordinance were implemented,” says Sister Mary Scullion, Executive Director of Project HOME, and a prime force in the Philadelphia advocacy community. Sister Mary and Street, who is now the mayor of Philadelphia, became co-chairs of an interagency Task Force designed to monitor implementation of the ordinance.

The 61 members of the Task Force represent a broad spectrum of the Philadelphia community, including business leaders, consumers, providers, foundations, faith organizations, and homeowners. Thus far, the group has overseen the following activities related to services, enforcement, and public education:

- Outreach has been expanded to 24 hours a day, and the number of mental health and substance abuse outreach and case management workers has more than doubled.
- One hundred sixty new residential placements for homeless people with mental health and substance abuse disorders have been created. These include two safe havens, a substance abuse recovery house, and 50 units of supportive, independent living.
- A public education campaign has distributed more than 20,000 brochures designed to educate people about the problem of homelessness and ways they can help.
- Training about the ordinance is now required for all current and prospective police officers.

A Sustained Effort

Can other communities replicate Philadelphia’s success? Perhaps, if they heed a warning from Sister Mary. “This isn’t a one-shot deal,” she says. “It takes the sustained effort of a number of people over a number of years to build a successful advocacy community.”

To get started, Fox suggests the following strategies:

- Invest others in solving the problem, but not just from your perspective. “We had to listen to members of the business community and understand their concerns, as well,” she says.
- Educate the community about models that work. Show them, don’t just tell them, that with the right mix of services, homeless people *can* be helped.
- Meet one-on-one with city leaders, an approach Fox calls “find a friend.”
- Offer alternatives and illustrate them in dollars and cents.

Finally, like Sister Mary, Fox recommends the creation of a strong advocacy community with a common mission. The relative success of the sidewalk behavior ordinance advocacy effort in Philadelphia, Fox says, is “a great example of a public/private endeavor that benefitted everyone.” For more information, contact Fox at (215) 985-2553. ▲

Anti-Homeless Legislation By the Numbers

- The **50** largest U.S. cities (in 1996) had some type of anti-homeless legislation (e.g., anti-begging, sleeping, or vagrancy ordinances).
- **16,000** “quality of life” violation tickets were issued by San Francisco police from January to November 1998.
- **5** cities’ policies qualify them as having the “meanest streets”: Atlanta, Chicago, New York City, San Francisco, and Tucson.
- It is **33%** more expensive to jail someone than to provide appropriate services.

Source: National Law Center on Homelessness and Poverty, *Out of Sight: Out of Mind?*, 1999. www.nlchp.org

Our Web Site Gets a New Look

The Information Resource Center Web site has a fresh new look! Check us out at www.prainc.com/hch and see the changes we've made so far. Look for a complete overhaul in the coming months, including new searchable databases for bibliographies, sample tools, and the HCH grantee directory.

Locate Free Medications Online

Volunteers in Health Care, supported through a grant from the Robert Wood Johnson Foundation, has created an online tool that helps health care providers locate sources of free pharmaceuticals for their uninsured patients. RxAssist (www.rxassist.org) features a searchable database with up-to-date information on accessing more than 100 manufacturers' programs.

Clinicians can locate programs that match their patients' needs and provide them with step-by-step instructions on how to apply, including eligibility standards. RxAssist can be searched by company name, brand name, generic name, or drug class. Users can also download many application forms and view a sample letter of need. To learn more about Volunteers in Health Care, log on to www.volunteersinhealthcare.org

or write them at 111 Brewster St., Pawtucket, RI 02860-9940.

New Resource for Transportation Assistance

Transportation services are always among the identified needs of homeless persons. The National Transit Resource Center of the Community Transportation Center of America (www.ctaa.org/ntrc) offers assistance (e.g., funding sources, exemplary practices, contacts) for communities working on transportation issues. The 2000 edition of the group's *Community Transportation Resource Guide* includes lists of federal funding resources for community transportation and regional and state transit associations. Copies are available for \$10 by calling (800) 527-8279. Portions of the guide are available online at www.ctaa.org/ct/resource.

Make a Note: We've Moved!

The HCH Information Resource Center has moved its offices. Our new address is: **345** Delaware Avenue, Delmar, NY 12054. Our toll-free number, (888) 439-3300, ext. 247, and e-mail address, hch@prainc.com, remain the same.

Nurses Learn about Clients by "Walking in Their Shoes"

"Welfare isn't under 'w' in the phone book."

"I felt like a second-class citizen."

"Food banks don't always provide grocery bags."

These are just a few of the reactions that Suzanne Gillette, RN, MPH, gets when she sends nursing students into the community to understand how clients obtain needed services. The key to this assignment, which Gillette uses in a community health nursing course at the University of Washington in Tacoma, is that students visit the agency they select without using their car. Gillette calls this exercise, "A Walk in Their Shoes: First Steps in Learning about a Community."

Most of Gillette's students—all of whom are registered nurses returning for their bachelor's degrees—have little, if any, community nursing experience. They conduct home visits with clients in private homes, as well as in shelters, groups homes, and doubled-up living situations. "That in itself can be an eye opener," Gillette says.

To find their way to a community agency, the nursing students walk, ride a bike, take a bus, or barter for a ride. Some give up a full day of work to do so, and many take their children with them, just as their clients would.

Once they locate the agency, the students learn as much as they can about available services without pre-

tending to be a client. Some discover agencies with friendly staff, easy application processes, and pleasant surroundings. Others find organizations with negative staff-client interactions, lengthy and complicated applications, and no child care.

The students summarize their experiences in a written report and in group discussions. Typically, Gillette says, students "gain tremendous respect for their clients' ingenuity and energy." They also become more effective advocates for their clients with the agencies that serve them.

For more information on "A Walk in Their Shoes," contact Gillette at (206) 784-9391 or gillette@u.washington.edu. ▲

CDC Seeks to Identify Patients with Hepatitis C

Individuals who received a transfusion of blood or blood components prior to July 1992 are at increased risk for hepatitis C virus (HCV) infection. As part of the Centers for Disease Control and Prevention's (CDC) National Hepatitis C Prevention Strategy, the agency hopes to identify and test persons who received blood, blood components, or organ transplants before July 1992.

The CDC also recommends that health care providers screen patients with other known risk factors, including injection of illegal drugs or exposure to HCV-positive blood. Homeless individuals who inject drugs or who are HIV-positive may be especially vulnerable. Though some individuals, including those actively engaging in substance abuse, are not candidates for treatment, providers can educate them about risk factors to help prevent the transmission of HCV to uninfected persons.

The CDC estimates that of the 3.9 million Americans who have been infected with HCV, approximately 300,000 acquired their infection through a blood transfusion. Currently, blood collection agencies and hospital transfusion services are conducting a targeted "look-back" to identify some of these infected persons. A targeted lookback identifies patients transfused with blood or blood components obtained from a donor who was

found to be HCV positive when testing became available. This effort would not identify persons who received blood from a donor who donated before such testing became available, persons who cannot be located by the transfusion service, persons for whom transfusion records no longer exist, and persons who received transfusions outside of the United States.

Patients likely to have received transfusions include:

- adults and children undergoing cardiac surgery
- trauma patients
- patients undergoing orthopedic surgery
- patients with gastrointestinal disease or undergoing surgery
- patients with hematologic disorders
- oncology patients
- women undergoing gynecologic surgery
- women undergoing cesarean-section or routine vaginal delivery when replacement of normal blood loss was common practice
- premature infants

In April 2000, a media campaign featuring Surgeon General David Satcher, MD, began airing nationwide. For more information on hepatitis C, consult the CDC Hepatitis Branch Web site at www.cdc.gov/hepatitis or call 1-888-4HEPCDC (1-888-443-7232).



Department of Health & Human Services

Health Resources and Services Administration
Bureau of Primary Health Care

Health Care for the Homeless
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